DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/29/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155630	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		COM	(X3) DATE SURVEY COMPLETED 08/16/2011		
NAME OF PROVIDER OR SUPPLIER FLATROCK RIVER LODGE			STREET ADDRESS, CITY, STATE, ZIP CODE 904 EAST 11TH STREET RUSHVILLE, IN46173					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF PREFIX (EACH CORRECTIVE ACTIVE ACTIV		ON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
	This visit was a I (PSR) to the Rec Licensure survey This visit was in investigation of of IN00094640. Survey dates: A Facility number: Provider number Aim number: Survey team: Sharon Lasher R Angel Tomlinson 2011) Leslie Parrett RN Cheryl Fielden R Census bed type: SNF/NF: 5. Residential: Total: 6 Census payor type Medicare: Medicaid: Residential:	Post Survey Revisit ertification and State completed on 6/24/11. conjunction with the complaint number august 15 and 16, 2011 001126 : 155630 200011300 N, TC a RN (August 15, 2011) (August 15, 2011) (August 15, 2011) (August 15, 2011)		CROSS-REFERENCED TO 1	THE APPROPRIATE	1		
LABORATOR	Y DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIG	GNATURE	TITLE		(X6) DATE		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

55UK12

Facility ID:

001126

If continuation sheet

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DUIL DING 00		00	COMPLETED			
		155630	A. BUILDING			- 08/16/2011			
		133333	B. WIN			00/10/2			
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE				
			904 EAST 11TH STREET						
FLATROCK RIVER LODGE			RUSHVILLE, IN46173						
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIES		ID			(X5)		
	SUMMARY STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR		PROVIDER'S PLAN OF CORRECTION	SHOULD BE COMPLETION E APPROPRIATE			
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL				CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				
TAG		REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG DEFICIENCY)			DATE		
	Total:	65							
	Sample: 8								
	Sample. 6								
			1						
	Flatrock River Lodge was found to be in		1						
	compliance with 42 CFR Part 483,								
	Subpart B and 410 IAC 16.2, in regard to								
	_	_							
	the PSR to the recertification and state								
	licensure survey	'.							
	Quality review completed 8/18/11								
	Cathy Emswiller RN								
	Camy Emswine	IKN							
			1						
			1						
			1						

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